APA: Bupropion and Nefazodone Cause Less Sexual Dysfunction Than Other New Generation Antidepressants

NEW ORLEANS, LA -- May 8, 2001 -- In the first study to examine the prevalence of sexual dysfunction across the new generation antidepressants, researchers reported at the American Psychiatric Association annual meeting that while the drug classes known as selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs) were associated with a higher rate of sexual dysfunction, other antidepressants were associated with significantly lower rates, namely bupropion and nefazodone. These data suggest that some sexual dysfunction is related to serotonergic antidepressant therapy.

In the overall study population, Wellbutrin SR® (bupropion HCl) Sustained-Release was associated with the lowest rate of sexual dysfunction (25 percent) after Wellbutrin® (bupropion HCl) (22 percent), compared with an average of approximately 40 percent across the SSRIs, venlafaxine and mirtazapine. In a subgroup of patients free of other probable causes of sexual dysfunction, the prevalence rate of sexual dysfunction ranged from 7 percent of patients receiving Wellbutrin SR to 23-30 percent for patients receiving the other antidepressants, including fluoxetine, citalopram and venlafaxine XR.

The multicenter study included a total of 6,297 patients enrolled at 1,101 primary care offices throughout the United States and evaluated 10 different new generation antidepressants. The study required patients to provide direct responses to questions about their sexual functioning in a written questionnaire and via a one-on-one patient/physician discussion. Sexual functioning was measured using a validated rating scale, the Changes in Sexual Functioning Questionnaire (CSFQ), providing consistent methodology to compare sexual dysfunction rates across the newer antidepressants.
"The SSRIs are known to cause sexual dysfunction as a side effect, but until now, there hasn't been a study to look at all the new generation antidepressants to see how they compare," said lead investigator Anita Clayton, M.D., associate professor and vice chair of the Department of Psychiatric Medicine at the University of Virginia (UVA) and medical director for the UVA Center for Psychiatric Clinical Research. "Physicians and patients are generally reluctant to talk about sexual problems. Therefore, physicians often underestimate the prevalence of antidepressant-associated sexual dysfunction and the impact on patients, as shown in this study," added Dr. Clayton.

In support of this point, Dr. Clayton described additional study findings where patient reports of sexual dysfunction were almost two times greater on average than that perceived by physicians. Prior to the study, physicians predicted a 20 percent prevalence rate in the overall population across new generation antidepressants, while 37 percent of patients reported having sexual dysfunction. Furthermore, 91 percent of patients said they would like the option to switch their antidepressant if they experience sexual side effects, while only 56 percent of physicians reported switching patient's antidepressant medication for that reason. Also, nearly half (42 percent) of the patients said that their physician had not discussed sexual functioning with them prior to the study.
Sexual dysfunction, which can include decreased interest in sex, inability or difficulty becoming aroused, and lack of or delayed orgasm, can impact a patient's quality of life, affect medication compliance and interfere with recovery from depression, according to Dr. Clayton.

"Loss of libido can be a symptom of depression, making it difficult to distinguish the symptom from the side effect. This study demonstrates that physicians would get a more accurate assessment of sexual problems by directly asking patients, rather than relying on voluntary reports," said Dr. Clayton.

The study enrolled patients receiving one new generation antidepressant for treating depression, at least 18 years of age, sexually active during the prior 12 months, and willing to discuss his or her sexual functioning with their physician. The majority of participants were women (72 percent), married (70 percent) and the average age was 43 years old. The prospectively defined subgroup analysis focused on patients who were free of other probable causes of sexual dysfunction. The subgroup criteria were: ages 18 to 40 years old, have had no sexual dysfunction with a previous antidepressant or no prior antidepressant treatment, had at least 3 months treatment with their current antidepressant, were not

taking concomitant medications nor had a medical illness that is known to cause sexual dysfunction, and had a history of at least some sexual enjoyment. Although the subpopulation analysis attempted to control for probable causes of sexual dysfunction, other possible causes could not be ruled-out.

These findings reinforce results from a separate survey conducted by the National Depressive and Manic-Depressive Association (National DMDA), a non-profit, patient advocacy group based in Chicago, Illinois, regarding patient/physician communication gaps, particularly with topics that are awkward to discuss, including sexual side effects. According to the National DMDA study, 69 percent of physicians said they usually mention sexual problems as a possible side effect, while significantly fewer patients (16 percent) recalled that their physician ever mentioned sexual side effects to them. In addition, just 36 percent of patients said their primary care doctor had asked about their preferences or willingness to tolerate certain side effects before deciding which antidepressants to prescribe.

According to the National Institute on Mental Health and the White House Conference on Mental Health, depression affects more than 22 million adults and is the cause of over two-thirds of the 30,000 reported suicides in the U.S. each year. Primary care physicians are treating more and more patients with depression and last year wrote nearly twice the number of prescriptions for antidepressant medication as psychiatrists (*JAMA*. 2001; 253:1431-1433).

Wellbutrin SR (bupropion HCl) Sustained-Release, a norepinephrine and dopamine reuptake inhibitor (NDRI), is indicated for the treatment of depression. Wellbutrin SR is contraindicated in patients with a seizure disorder as well as those treated with Zyban® (bupropion HCl) Sustained Release Tablets, or any other medications that contain bupropion. Wellbutrin SR is also contraindicated in patients with a current or prior diagnosis of bulimia or anorexia nervosa, or who are concurrently taking a monoamine oxidase (MAO) inhibitor. In managing a patient's depressive episode, a physician should be aware that the drug may cause seizures in a dose-related manner. Similar to other antidepressants, the incidence of seizure is approximately 0.1 percent at the recommended daily dose of 300mg. The incidence increases to approximately 0.4 percent at the maximum daily dose of 400mg. When treating patients with severe hepatic cirrhosis, extreme caution should be exercised and a reduced dosage and/or frequency is required to avoid accumulation. There have been reports of hypertension, in some cases severe, in patients receiving bupropion alone and in combination with nicotine replacement therapy.